When you log in to efileshare.com you will click on the Physician Referrals tab. There are 4 sections to the request (1. Start, 2. Patient, 3. Select Office and 4. Preview and Send). The fields below have numbers highlighted in yellow that correlate with these sections.

ALABAMA MEDICAID AGENCY REFERRAL FORM

Today's Date _____ Referral Date _____

RECIPIENT INFORMATION

Recipient Name	Recipient #	Recipient DOB:
2. Name	2. Policy Number	2. DOB

PRIMARY PHYSICIAN	SCREENING PROVIDER (IF DIFFERENT)
Name 3. From	Name N/A to Efileshare
Address 3. Information Auto Plugged	Address Can indicate difference in notes
Telephone #: ( )	Telephone #: ( )
Fax #: ( ) 3. Information Auto Plugged	Fax # :( )
Provider #	Provider #
Signature	Signature

TYPE OF REFERRAL

Patient 1st 3. Reason for Exam	❑ Lock-in
❑ EPSDT Screening Date _____ Will have to type in vs. checkbox	❑ Patient 1st/EPSDT Screening Date _____
❑ Targeted Case Management (TCM)	

LENGTH OF REFERRAL

Referral Valid for _____month (s) or _____visit (s) from referral date 1. Authorization Expires/Number of Visits

REFERRAL VALID FOR

❑ Evaluation Only 3. Other Notes	❑ Treatment Only
❑ Evaluation and Treatment	❑ Hospital Care (Outpatient)
❑ Referral to other provider for identified condition Will have to type in vs. checkbox	❑ Performance of Interperiodic Screening (if necessary)
❑ Referral to other provider for additional conditions (diagnosed by consultant)	

Reason for Referral: 3. Diagnosis codes required

Co-morbid Diagnosis:

CONSULTANT INFORMATION

Consultant Name: 3. To Doctor/Facility Consultant Telephone #: ( ) 3. Auto plugged

Note: Please submit written report of findings including the date of examination/service, diagnosis, and consultant signature to primary physician.

Please submit findings to Primary Physician by:

❑ Mail Can be mailed	❑ Fax # with area code
❑ E-mail Returned e-mail	❑ In addition, please telephone